Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THOMAS LEONARD, MD
PO BOX 121589
ARLINGTON TX 76012

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-0191-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid per the DWC Fee Guidelines"

Amount in Dispute: $1,240.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor determined disability was the direct result of the injury. The requestor billed $500.00 for this was paid $0.0 as this was outside what the requestor was asked to do."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2010	CPT Codes 99456-W5-NM, 99456-W6-RE, 99456-W7-RE, 99456-W8-RE, 99080-73	$1,240.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 6, 2010

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- 225 – THE SUMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED, WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE.

Explanation of benefits dated June 3, 2010 with above codes as well as the additional reason codes:

- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- CAC-214 – WORKERS' COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT. (NOTE: TO BE USED FOR WORKERS' COMPENSATION ONLY).

Per a phone conversation with requestor on September 2, 2011, the only services disputed at this time are CPT code 99456-W7-RE for "DIRECT RESULT" determination in the disputed amount of $125.00 as a 3rd non-MMI/IR examination. The services for MMI/IR, RTW, and EXT have been paid as well as the DWC-73 report. The requestor's Table of Disputed Services represents the entire billing as unpaid. However, EOBs submitted from both requestor and respondent indicate payment via bulk check number #10519464 in the amount of $1,115.00. Therefore, MFDR will address the charge for "DIRECT RESULT", CPT code 99456-W7-RE charge of $500.00 which is disputed for the amount of $125.00 as the 3rd non-MMI/IR examination.

Issues

1. Did the requestor submit documentation to support the disputed services were submitted in accordance with Texas Administrative Code, Section §134.204 and the DWC request for Designated Doctor services on the EES-14 notification form?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204, the services rendered were billed with proper modifier use. However, review of the submitted documentation finds that the DWC EES-14 notification only specified that Maximum Medical Improvement, Impairment Rating, Extent of Injury and Return to Work examinations were to be accomplished. The respondent used denial code CAC-214 on one line item 99456-W7-RE indicating that the claim is non-compensable but there is no PLN-1 regarding overall compensability of this claim. As for denial based on specific service or treatment, the carrier denies the 99456-W7-RE due to a lack of order by DWC for Designated Doctor to perform a "DIRECT RESULT" examination. The Division determines that there was no order to perform a "DIRECT RESULT" examination and therefore it is not payable.

2. In accordance with 28 Texas Administrative Code §134.204, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 15, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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